CHAPTER VI

BILLING INSTRUCTIONS

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GENERAL INFORMATION

To bill the Virginia Medicaid Program for prosthetic devices provided to Medicaid recipients, the provider may need to obtain prior authorization for the prosthetic device. (See Chapters IV and V for prior authorization requirements and process). After receiving an approved authorization and delivering the prosthetic device to the enrollee, the provider may submit a claim for reimbursement. (Note: Refer to Billing Procedures and Instructions for the Use of the CMS-1500 (12-90) Billing Form sections of this chapter for Prosthetic Device reimbursement information).

ELECTRONIC SUBMISSION OF CLAIMS

Electronic billing is a fast and effective way to submit Medicaid claims. Claims will be processed faster and more accurately because electronic claims are entered in to the claims processing system directly. For more information contact our fiscal agent, First Health Services Corporation:

Phone: (800) 924-6741
Fax number: (804) 273-6797

First Health's website: http://virginia.fhsc.com
E-mail: edivmap@fhsc.com

Mailing Address

EDI Coordinator-Virginia Operations
First Health Services Corporation
4300 Cox Road
Richmond, Virginia 23060

TIMELY FILING

The Medical Assistance Program regulations require the prompt submission of all claims. Virginia Medicaid is mandated by federal regulations to require the initial submission of all claims (including accident cases) within 12 months from the date of service. Providers are encouraged to submit billings within 30 days from the last date of service or discharge. Federal financial participation is not available for claims which **are not** submitted within 12 months from the date of the service. If billing electronically and timely filing must be waived, submit the DMAS-3 form with the appropriate attachments. The DMAS-3 form is to be used by electronic billers for attachments. (See Exhibits) Medicaid is not authorized to make payment on these late claims, except under the following conditions:

- **Retroactive Eligibility** - Medicaid eligibility can begin as early as the first day of the third month prior to the month of application for benefits. All eligibility requirements must be met within that time period. Unpaid bills for that period can be billed to Medicaid the same as for any other service. If the enrollment is not accomplished timely, billing will be handled in the same manner as for delayed eligibility.

- **Delayed Eligibility** - Medicaid may make payment for services billed more than 12 months from the date of service in certain circumstances. Medicaid denials may be overturned or other actions may cause eligibility to be established for a prior period. Medicaid may make payment for dates of service more than 12 months in the past when the claims are for an enrollee whose eligibility has been delayed. It is the provider's obligation to verify the patient's Medicaid eligibility. Providers who have rendered care for a period of delayed eligibility will be notified by a copy of a letter from the local department of social services which specifies the delay has occurred, the Medicaid claim number, and the time span for which eligibility has been granted.

  The provider must submit a claim on the appropriate Medicaid claim form within 12 months from the date of the notification of the delayed eligibility. A copy of the dated letter from the local department of social services indicating the delayed claim information must be attached to the claim. On the CMS-1500 (12-90) form, enter "ATTACHMENT" in Locator 10d and indicate "Unusual Service" by entering Procedure Modifier "22" in Locator 24D.

- **Denied Claims** - Denied claims submitted initially within the required 12-month period may be resubmitted and considered for payment without prior approval from Medicaid. The procedures for resubmission are:

  - Complete the CMS-1500 (12-90) invoice as explained under the "Instructions for the Use of the CMS-1500 (12-90) Billing Form" elsewhere in this chapter.

  - **Attach** written documentation to verify the explanation. This documentation may be denials by Medicaid or any follow-up correspondence from Medicaid showing that the claim was submitted to Medicaid initially within the required 12-month period. If billing electronically and waiver of timely filing is being requested, submit the claim with the appropriate attachments. (The DMAS-3 form is to be used by electronic billers for attachments. See Exhibits).

  - Indicate Unusual Service by entering "22" in Locator 24D of the CMS-1500 (12-90) claim form.

  - Submit the claim in the usual manner by mailing the claim to:

    Department of Medical Assistance Services
    Practitioner
    P. O. Box 27444
    Richmond, Virginia 23261-7444

Submit the original copy of the claim form to Medicaid. Retain a copy for record keeping. All invoices must be mailed; proper postage is the responsibility of the provider and will help prevent mishandling. Envelopes with insufficient postage will be returned to the provider. Messenger or hand deliveries will not be accepted.

- **Accident Cases** - The provider may either bill Medicaid or wait for a settlement from the responsible liable third party in accident cases. However, all claims for services in accident cases must be billed to Medicaid within 12 months from the date of the service. If the provider waits for the settlement before billing Medicaid and the wait extends beyond 12 months from the date of the service, no reimbursement can be made by Medicaid as the time limit for filing the claim has expired.

- **Other Primary Insurance** - The provider should bill other insurance as primary. However, all claims for services **must be billed to Medicaid within 12 months from the date of the service.** If the provider waits for payment before billing Medicaid and the wait extends beyond 12 months from the date of the service, no reimbursement can be made by Medicaid as the time limit for filing the claim has expired. If payment is made from the primary insurance carrier after a payment from Medicaid has been made, an adjustment or void should be filed at that time.

REQUESTS FOR BILLING MATERIALS

The CMS-1500 (12-90) Health Insurance Claim Form is a universally accepted claim form that is required when billing DMAS for covered services. The form is available from forms printers and the U.S. Government Printing Office. Specific details on purchasing these forms can be obtained by writing to the following address:

Superintendent of Documents
P.O. Box 371954
Pittsburgh, PA 51250-7954

The CMS-1500 (12-90) claim form will not be provided by DMAS.

As a general rule, DMAS will no longer provide a supply of agency forms, which can be down-loaded, from the DMAS web site (www.dmas.virginia.gov) (***please note the new DMAS website address***). To access the forms, click on the "Search Forms" function on the left-hand side of the DMAS home page and select "provider" to access provider forms. Then you may either search by form name or number.

If you do not have Internet access, you may request a form for copying by calling the DMAS form order desk at 1-804-780-0076.

DMAS sends a check and remittance voucher with each weekly payment made by the Virginia Medical Assistance Program. The remittance voucher is a record of approved, pended, denied, adjusted, or voided claims and should be kept in a permanent file for five (5) years.

The remittance voucher includes an address location, which contains the provider's name and current mailing address as shown in DMAS' provider enrollment file. In the event of a change-of-address, the U.S. Postal Service **will not** forward Virginia Medicaid payment checks and vouchers to another address. Therefore, it is recommended that DMAS' Provider Enrollment and Certification Unit be notified in sufficient time prior to a change-of-address in order for the provider files to be updated.

Providers are encouraged to monitor the remittance vouchers for special messages since they serve as notifications of matters of concern, interest and information. For example, such messages may relate to upcoming changes to Virginia Medicaid policies and procedures; may serve as clarification of concerns expressed by the provider community in general; or may alert providers to problems encountered with the automated claims processing and payment system.

ANSI X12N 835 HEALTH CARE CLAIM PAYMENT ADVICE

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicaid, comply with the electronic data interchange (EDI) standards for health care as established by the Secretary of Health and Human Services. The 835 Claims Payment Advice transaction set is used to communicate the results of claim adjudication. DMAS will make a payment with an electronic funds transfer (EFT) or check for a claim that has been submitted by a provider (typically by using an 837 Health Care Claim Transaction Set). The payment detail is electronically posted to the provider's accounts receivable using the 835. In addition to the 835 the provider will receive an unsolicited 277 Claims Status Response for the notification of pending claims. For technical assistance with certification of the 835 Claim Payment Advice please contact our fiscal agent, First Health Services Corporation, at (800) 924-6741.

CLAIM INQUIRIES

Inquiries concerning covered benefits, specific billing procedures, or questions regarding Virginia Medicaid policies and procedures should be directed to:

Customer Services
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

Telephone Numbers

1-804-786-6273	Richmond Area and out-of-state long distance
1-800-552-8627	In-state long distance (toll-free)

Enrollee verification and claim status may be obtained by telephoning:

1-800- 772-9996	Toll-free throughout the United States
1-800-884-9730	Toll-free throughout the United States

(804) 965-9732 Richmond and Surrounding Counties
(804) 965-9733 Richmond and Surrounding Counties

Enrollee verification and claim status may also be obtained by utilizing the Web-based Automated Response System. See Chapter I for more information.

BILLING PROCEDURES

The appropriate claim form or billing invoice must be used by physicians and other practitioners when billing the Virginia Medicaid Program for covered services provided to eligible Medicaid enrollees. Each enrollee's services must be billed on a separate form.

The provider should carefully read and adhere to the following instructions so that claims can be processed efficiently. Accuracy, completeness, and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Completed claims should be mailed to:

Department of Medical Assistance Services
Practitioner
P.O. Box 27444
Richmond, Virginia 23261-7444

ELECTRONIC FILING REQUIREMENTS

The Virginia MMIS is HIPAA-compliant and, therefore, supports all electronic filing requirements and code sets mandated by the legislation. Accordingly, National Standard Formats (NSF) for electronic claims submissions after December 31, 2003 are no longer accepted, and all local service codes are no longer accepted for claims with dates of service after December 31, 2003. All claims submitted with dates of service after December 31, 2003 will be denied if local codes are used.

On June 20, 2003, DMAS began accepting EDI transactions according to the specifications published in the ASC X12 Implementation Guides version 4010A1 (HIPAA-mandated). Beginning with electronic claims submitted on or after January 1, 2004, DMAS accepts only HIPAA-mandated EDI transactions (claims in National Standard Formats will no longer be accepted). National Codes that replace Local Codes are accepted for claims with dates of service on or after June 20, 2003. National Codes become mandatory for claims with dates of service on or after January 1, 2004.

The Virginia MMIS will accommodate the following EDI transactions according to the specifications published in the ASC X12 Implementation Guides version 4010A1:

- 837P for submission of profession claims
- 837I for submission of institutional claims
- 837D for submission of dental claims
- 276 & 277 for claims status inquiry and response

- 835 for remittance advice information for adjudicated claims (paid and denied)
- 270 & 271 for eligibility inquiry and response
- 278 for prior authorization request and response.
- Unsolicited 277 for reporting information on pended claims

Although not mandated by HIPAA, DMAS has opted to produce an Unsolicited 277 transaction to report information on pended claims. Information on these transactions can be obtained from our fiscal agent's website: http://virginia.fhsc.com.

CLAIMCHECK

ClaimCheck is a fully automated auditing system that verifies the clinical accuracy of claims submitted and reimbursed. DMAS uses ClaimCheck as a post-payment review of professional and laboratory claims. As a result of this auditing process, DMAS makes the necessary voids or adjustment of the claim(s).

INSTRUCTIONS FOR THE USE OF THE CMS-1500 (12-90) BILLING FORM

To bill for services, the Health Insurance Claim Form, CMS-1500 (12-90), invoice form must be used. The following instructions have numbered items corresponding to fields on the CMS-1500. **The required fields to be completed are printed in boldface. Where more specific information is required in these fields, the necessary information is referenced in the locator requiring the information and provider-specific instructions are found later in this chapter.**

Instructions for the Completion of the Health Insurance Claim Form, CMS-1500 (12-90), Billing Invoice

The purpose of the CMS-1500 is to provide a form for participating providers to request reimbursement for covered services rendered to Virginia Medicaid recipients. (A sample of a completed CMS-1500 claim form follows the instructions for its use).

Locator		Instructions
1	**REQUIRED**	**Enter an "X" in the MEDICAID box.**
1a	**REQUIRED**	**Insured's I.D. Number - Enter the 12-digit Virginia Medicaid Identification number for the recipient receiving the service.**
2	**REQUIRED**	**Patient's Name - Enter the name of the recipient receiving the service.**
3	NOT REQUIRED	Patient's Birth Date
4	NOT REQUIRED	Insured's Name
5	NOT REQUIRED	Patient's Address
6	NOT REQUIRED	Patient Relationship to Insured
7	NOT REQUIRED	Insured's Address
8	NOT REQUIRED	Patient Status
9	NOT REQUIRED	Other Insured's Name
9a	NOT REQUIRED	Other Insured's Policy or Group Number
9b	NOT REQUIRED	Other Insured's Date of Birth and Sex
9c	NOT REQUIRED	Employer's Name or School Name

Locator		Instructions
9d	NOT REQUIRED	Insurance Plan Name or Program Name
10	**REQUIRED**	**Is Patient's Condition Related To: - Enter an "X" in the appropriate box. (The "Place" is NOT REQUIRED.) a. Employment? b. Auto Accident? c. Other Accident? (This includes schools, stores, assaults, etc.)**
10d	**CONDITIONAL**	**Enter "ATTACHMENT" if documents are attached to the claim form and procedure modifier "22" (unusual services) is used.**
11	NOT REQUIRED	Insured's Policy Number or FECA Number
11a	NOT REQUIRED	Insured's Date of Birth
11b	NOT REQUIRED	Employer's Name or School Name
11c	NOT REQUIRED	Insurance Plan or Program Name
11d	NOT REQUIRED	Is There Another Health Benefit Plan?
12	NOT REQUIRED	Patient's or Authorized Person's Signature
13	NOT REQUIRED	Insured's or Authorized Person's Signature
14	NOT REQUIRED	Date of Current Illness, Injury, or Pregnancy
15	NOT REQUIRED	If Patient Has Had Same or Similar Illness
16	NOT REQUIRED	Dates Patient Unable to Work in Current Occupation
17	**CONDITIONAL**	**Name of Referring Physician or Other Source**
17a	**CONDITIONAL**	**I.D. Number of Referring Physician - Enter the Virginia Medicaid number of the referring physician. See the following pages for special instructions for your services.**
18	NOT REQUIRED	Hospitalization Dates Related to Current Services
19	NOT REQUIRED	Reserved for Local Use
20	**CONDITIONAL**	**CLIA #**

Locator		Instructions
21	**REQUIRED**	**Diagnosis or Nature of Illness or Injury - Enter the appropriate ICD-9 CM diagnosis, which describes the nature of the illness or injury for which the service was rendered.**
22	**CONDITIONAL**	**Medicaid Resubmission - Required for adjustment and void. See the instructions for Adjustment and Void Invoices.**
23	**CONDITIONAL**	**Prior Authorization Number - Enter the PA number for the approved device.**
24A	**REQUIRED**	**Dates of Service - Enter the from and thru dates in a 2-digit format for the month, day, and year (e.g., 04/01/99). DATES MUST BE WITHIN THE SAME CALENDAR MONTH.**
24B	**REQUIRED**	**Place of Service - Enter the 2-digit national place of service code, which describes where the services were rendered.**
24C	**REQUIRED**	**Type of Service - Enter the one-digit national code for the type of service rendered.**
24D	**REQUIRED**	**Procedures, Services or Supplies-** **CPT/HCPCS - Enter the 5-character CPT/HCPCS Code, which describes the procedure rendered or the service provided. See the attached code list for special instructions if appropriate for your service.** **Modifier - Enter the appropriate HCPCS/CPT modifiers if applicable. NOTE: Use modifier "22" for individual consideration. Claims will pend for manual review of attached documentation.**
24E	**REQUIRED**	**Diagnosis Code - Enter the entry identifier of the ICD-9-CM diagnosis code listed in Locator 21 as the primary diagnosis. Claims with values other than 1, 2, 3, or 4 in Locator 24-E may be denied. Must be values 1, 2, 3 or 4 only.**
24F	**REQUIRED**	**Charges - Enter your total usual and customary charges for the procedure/services. See the special instructions following these instructions if applicable for your service.**

Locator		Instructions
24G	**REQUIRED**	**Days or Unit - Enter the number of times the procedure, service, or item was provided during the service period. See the pages following the instructions for special instructions if applicable to your service.**
24H	**CONDITIONAL**	**EPSDT or Family Planning - Enter the appropriate indicator. Required only for EPSDT or family planning services.** **1 - Early and Periodic, Screening, Diagnosis and Treatment Program Services** **2 - Family Planning Service**
24I	**CONDITIONAL**	**EMG (Emergency) - Place a "1" in this block if the services are emergency-related. Leave blank if not an emergency.**
24J	**REQUIRED**	**COB (Primary Carrier Information) - Enter the appropriate code. See special instructions if required for your service.** **2 - No Other Carrier** **3 - Billed and Paid** **5 - Billed, No Coverage. All claims submitted with a Coordination of Benefits (COB) code of 5 must have an attachment documenting one of the following:** • **The Explanation of Benefits (EOB) from the primary carrier; or** • **A statement from the primary carrier that there is no coverage for this service; or** • **An explanation from the provider that the other insurance does not provide coverage for the service being billed (e.g., this is a claim for surgery and the other coverage is dental); or** • **A statement from the provider indicating that the primary insurance has been canceled.** **Claims with no attachment will be denied.**
24K	**REQUIRED**	**Reserved for Local Use - Enter the dollar amount**

Locator		Instructions
		received from the primary carrier if Block 24J is coded "3". See special instructions if required for your service.
25	NOT REQUIRED	Federal Tax I.D. Number
26	OPTIONAL	Patient's Account Number – Up to seventeen alpha-numeric characters are acceptable.
27	NOT REQUIRED	Accept Assignment
28	NOT REQUIRED	Total Charge
29	NOT REQUIRED	Amount Paid
30	NOT REQUIRED	Balance Due
31	**REQUIRED**	**Signature of Physician or Supplier Including Degrees or Credentials - The provider or agent must sign and date the invoice in this block.**
32	NOT REQUIRED	Name and Address of Facility Where Services Were Rendered
33	**REQUIRED**	**Physician's, Supplier's Billing Name, Address ZIP Code & Phone # - Enter the provider's billing name, address, ZIP Code, and phone number as they appear in your Virginia Medicaid provider record. Enter your Virginia Medicaid provider number (servicing provider) in the PIN # field. Ensure that your provider number is distinct and separate from your phone number or ZIP Code. Enter Group # (billing provider number) if applicable.**

Instructions for the Completion of the Health Insurance Claim Form, CMS-1500 (12-90), as an Adjustment Invoice

The Adjustment Invoice is used to change information on a paid claim. Follow the instructions for the completion of the Health Insurance Claim Form, CMS-1500 (12-90), except for the locator indicated below.

Locator 22 **Medicaid Resubmission**

Code - Enter the 4-digit code identifying the reason for the submission of the adjustment invoice.

1023 Primary Carrier has made additional payment
1024 Primary Carrier has denied payment
1025 Accommodation charge correction
1026 Patient payment amount changed
1027 Correcting service periods
1028 Correcting procedure/service code
1029 Correcting diagnosis code
1030 Correcting charges
1031 Correcting units/visits/studies/procedures
1032 IC reconsideration of allowance, documented
1033 Correcting admitting, referring, prescribing, provider identification number
1053 Adjustment reason is in the Misc. Category

Original Reference Number/ICN - Enter the claim reference number/ICN of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be adjusted. Only one claim can be adjusted on each CMS-1500 submitted as an Adjustment Invoice. (Each line under Locator 24 is one claim).

Instructions for the Completion of the Health Insurance Claim Form CMS-1500 (12-90), as a Void Invoice

The Void Invoice is used to void a paid claim. Follow the instructions for the completion of the Health Insurance Claim Form, CMS-1500 (12-90), except for the locator indicated below.

Locator 22 **Medicaid Resubmission**

Code - Enter the 4-digit code identifying the reason for the submission of the void invoice.

1042 Original claim has multiple incorrect items
1044 Wrong provider identification number
1045 Wrong enrollee eligibility number
1046 Primary carrier has paid DMAS maximum allowance
1047 Duplicate payment was made
1048 Primary carrier has paid full charge
1051 Enrollee not my patient
1052 Void Reason is in miscellaneous category
1060 Other insurance is available

Original Reference Number/ICN - Enter the claim reference number/ICN of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be voided. Only one claim can be voided on each CMS-1500 submitted as a Void Invoice. (Each line under Locator 24 is one claim).

SPECIAL BILLING INSTRUCTIONS - CLIENT MEDICAL MANAGEMENT (CMM) PROGRAM

The primary care physician (PCP) and any other provider who is part of the PCP'S CMM Affiliation Group bills for services in the usual manner, but other physicians must follow special billing instructions to receive payment. (Affiliation Groups are explained in Chapter I under CMM.) Other physicians must indicate a PCP referral or an emergency unless the service is excluded from the requirement for a referral. Excluded services are listed in Chapter I.

All services should be coordinated with the primary health care provider whose name is provided at the time of verification of eligibility. The CMM PCP referral does not override Medicaid service limitations. All DMAS requirements for reimbursement, such as pre-authorization, still apply as indicated in each provider manual.

When treating a restricted enrollee, a physician covering for the primary care physician or on referral from the primary care physician must place the primary care physician's Medicaid provider number in Locator 17a and attach a copy of the Practitioner Referral Form (DMAS-70) to the invoice.

In a medical emergency situation, if the practitioner rendering treatment is not the primary care physician, he or she must certify that a medical emergency exists for payment to be made. The provider must enter a "1" in Locator 24I and attach an explanation of the nature of the emergency.

LOCATOR	SPECIAL INSTRUCTIONS
10d	Write "ATTACHMENT" for the Practitioner Referral Form, DMAS-70, or for remarks as appropriate.
17a	When a restricted enrollee is treated on referral from the primary care physician, enter the primary care physician's Medicaid provider number (as indicated on the DMAS-70 referral form) and attach a copy of the Practitioner Referral Form to the invoice. Write "ATTACHMENT" in Locator 10d.
24I	When a restricted enrollee is treated in an emergency situation by a provider other than the primary care physician, the non-designated physician enters a "1" in this Locator and explains the nature of the emergency in an attachment. Write "ATTACHMENT" in Locator 10d.

EDI Billing (Electronic Claims)

Follow the instructions for the 837 transaction and the standard for attachments using the Claim Attachment Form (DMAS-3).

SPECIAL BILLING INSTRUCTIONS

MEDALLION

Primary Care Providers (PCP) bill for services on the Health Insurance Claim Form, CMS-1500 (12-90). The invoice is completed and submitted according to the instructions provided in the Medicaid Physician Manual.

To receive payment for their services, referral providers authorized by a client's PCP to provide treatment to that client must place the Medicaid Provider Identification Number of the PCP in Locator 17a of the CMS-1500. Subsequent referrals resulting from the PCP's initial referral will also require the PCP Medicaid provider number in this block.

INSTRUCTIONS FOR BILLING MEDICARE COINSURANCE AND DEDUCTIBLE

Virginia Medicaid purchases Medicare Part A and Part B coverage for all Medicaid recipients eligible for Medicare benefits and makes payment to providers for Medicare coinsurance and deductible.

The Medicare Program Part A and Part B Carriers serving Virginia and the Virginia Medicaid Program have developed a system whereby these carriers will send to Virginia Medicaid the Medicare Explanation of Benefits (EOB) for identified Virginia recipients. This information will be used by the Program to pay Medicare coinsurance and deductible amounts as determined by the carrier. Do not bill Virginia Medicaid directly for services rendered to Medicaid recipients who are also covered by Medicare Program Part A and Part B carriers serving Virginia. However, the DMAS-31 adjustment form may be used when needed.

If the Medicare Part A and Part B carrier is one of these, bill Medicare directly on the appropriate invoice.

Upon receipt of the Medicare EOB, Virginia Medicaid will process payment automatically to participating providers when the recipient's Medicare number and the provider's Medicare vendor/provider number are in the Medicaid files. Those providers billing Medicare under more than one Medicare vendor/provider number must identify these numbers and names to the Medicaid Program to update its files. Medicare vendor/provider number additions or deletions must also be sent to the Program.

This automatic payment procedure includes Medicaid recipients with Railroad Retirement Medicare benefits.

If problems are encountered, the DMAS-30 invoice form should be completed for Part B services, and a copy of the EOB attached and forwarded to:

Title XVIII
Department of Medical Assistance Services
P. O. Box 27441
Richmond, Virginia 23261-7441

NOTE: Medicaid eligibility is reaffirmed each month for most recipients. Therefore, bills must be for services provided during each calendar month, e.g., 01-01-99 - 01-31-99.

Instructions for the Completion of the Department of Medical Assistance Services (Title XVIII) Medicare Deductible and Coinsurance Invoice FOR PART B ONLY, DMAS-30 – R 6/03

Purpose: To provide a method of billing Virginia Medicaid for Medicare deductible and coinsurance.

NOTE: This form can be used for four different procedures **per** Medicaid recipient. A different form must be used for **each** Medicaid enrollee.

Block 01 **Provider's Medicaid ID Number** – Enter the Virginia Medicaid provider identification number assigned by Virginia Medicaid.

Block 02 **Recipient's Last Name** – Enter the last name of the patient as it appears from the enrollee's eligibility verification.

Block 03 **Recipient's First Name** – Enter the first name of the patient as it appears from the enrollee's eligibility verification.

Block 04 **Recipient ID Number** – Enter the 12-digit number taken from the enrollee's eligibility card.

Block 05 **Patient's Account Number** – Enter the financial account number assigned by the provider. This number will appear on the Remittance Voucher after the claim is processed.

Block 06 **Recipient's HIB Number (Medicare)** – Enter the enrollee's Medicare number.

Block 07 **Primary Carrier Information (Other Than Medicare)** – Check the appropriate block. (Medicare is not the primary carrier in this situation).

- **Code 2 – No Other Coverage** – If there is not other insurance information identified by the patient or no other insurance provided when the Medicaid eligibility is confirmed, check this block.
- **Code 3 – Billed and Paid** – When an enrollee has other coverage that makes a payment which may only satisfy in part the Medicare deductible and coinsurance, check this block and enter the payment in Block 22. If the primary carrier pays as much as the combined totals of the deductible and coinsurance, do not bill Medicaid.
- **Code 5 – Billed and No Coverage** – If the enrollee has other sources for the payment of Medicare deductible and coinsurance which were billed and the service was not covered or the benefits had been exhausted, check this block. Explain in the "Remarks" section.

Block 08 **Type of Coverage (Medicare)** – Mark type of coverage B only.

Block 09 **Diagnosis** – Enter the principal ICD-9-CM diagnosis code, omitting the decimal. Only one diagnosis code can be entered and processed.

Block 10 **Place of Treatment** – Enter the appropriate national place of service code.

Block 11 **Accident/Emergency Indicator** – Check the appropriate box, which indicates the reason the treatment, was rendered:

- **ACC** – Accident, Possible third-party recovery
- **Emer** – Emergency, Not an accident
- **Other** – If none of the above

Block 12 **Type of Service** – Enter the appropriate national code describing the type of service.

Block 13 **Procedure Code** – Enter the 5-digit CPT/HCPCS code that was billed to Medicare. Each procedure must be billed on a separate line. Use the appropriate national procedure code modifier if applicable.

Block 14 **Visits/Units/Studies** – Enter the units of service performed during the "Statement Covers Period" (block 16) as billed to Medicare.

Block 15 **Date of Admission** – Enter the date of admission (if applicable).

Block 16 **Statement Covers Period** – Using six-digit dates, enter the beginning and ending dates of this service (from) and the last date of this service (thru) (e.g., 03-01-03 to 03-31-03).

Block 17 **Charges to Medicare** – Enter the total charges submitted to Medicare.

Block 18 **Allowed by Medicare** – Enter the amount of the charges allowed by Medicare.

Block 19 **Paid by Medicare** – Enter the amount paid by Medicare (taken from the Medicare EOMB).

Block 20 **Deductible** – Enter the amount of the deductible (taken from the Medicare EOMB).

Block 21 **Co-insurance** – Enter the amount of the co-insurance (taken from the Medicare EOMB).

Block 22 **Paid by Carrier Other Than Medicare** – Enter the payment received from the primary carrier (other than Medicare). If the Code 3 is marked in Block 7, enter an amount in this block. (Do not include Medicare payments).

Block 23 **Patient Pay Amount, LTC Only** – Enter the patient pay amount, if applicable.

Block 24 **Remarks** – If an explanation regarding this claim is necessary, the "Remarks" section may be used. Submit only original claim forms and attach a copy of the EOMB to the claim.

Signature Note the certification statement on the claim form, then sign and date the claim form.

Instructions for the Completion of the Department of Medical Assistance Services (Title XVIII) Medicare Deductible and Coinsurance Adjustment Invoice FOR PART B ONLY, DMAS-31 (Revised 6/96)

Adjustment Coinsurance Invoice, DMAS-31 (Revised 6/96)

The adjustment invoice is used to change information on a **paid** claim. This form cannot be used for the follow-up of denied or pended claims.

Void Coinsurance Invoice, DMAS-31 (Revised 6/96)

The void invoice is used to void the original payment. The information on the invoice must be identical to the original invoice.

Purpose	To provide a means of making corrections or changes to claims that have been approved for payment. This form cannot be used for the follow-up of denied, or pended claims. (See the "Exhibits" section at the end of this chapter for a sample of this form).
Explanation	To void the original payment, the information on the adjustment invoice must be identical to the original invoice. To correct the original payment, the adjustment invoice must appear exactly as the original should have.
Block 1	**Adjustment/Void** - Check the appropriate block.
Block 2	**Provider Identification Number** – Enter the Virginia Medicaid provider identification number assigned by Virginia Medicaid.
Block 2A	**Reference Number** - Enter the reference number/ICN taken from the Remittance Voucher for the line of payment needing an adjustment. The adjustment cannot be made without this number since it identifies the original invoice.
Block 2B	**Reason** - Leave blank.
Block 2C	**Input Code** - Leave blank.
Block 3	**Clients' Name** - Enter the last name and the first name of the patient as they appear on the enrollee's eligibility card.
Block 4	**Client's Identification Number** - Enter the 12-digit number taken from the enrollee's eligibility card.
Block 5	**Patient Account Number** – Enter the financial account number assigned by the provider. This number will appear on the

Remittance voucher after the claim is processed.

Block 6 **Client HIB Number** (Medicare) - Enter the enrollee's Medicare number.

Block 7 **Primary Carrier Information (Other Than Medicare)** - Check the appropriate block. (Medicare is not the primary carrier in this situation).

- **Code 2 - No Other Coverage** –If there is no other insurance information identified by the patient or no other insurance provided when the Medicaid eligibility is confirmed, check this block.
- **Code 3 - Billed and Paid** - When an enrollee has other coverage that makes payment which may only satisfy in part the Medicare deductible and coinsurance, check Block 3 and enter the payment received in Block 19. If the primary carrier pays as much as the combined totals of the deductible and coinsurance, do not bill Medicaid.
- **Code 5 - Billed and No Coverage** - If the enrollee has other sources for the payment of Medicare deductible and coinsurance which were billed and the service was not covered or the benefits had been exhausted, check this block. Explain in the "Remarks" section.

Block 8 **Type Coverage (Medicare)** - Mark type of coverage "B".

Block 9 **Diagnosis** - Enter the primary ICD-9-CM diagnosis code, omitting the decimal. Only one code can be processed.

Block 9A **Place of Treatment** - Enter the appropriate national place of service code:

Block 10 **Accident Indicator** - Check the appropriate box which indicates the reason the treatment was rendered:

- **Accident** - Possible third-party recovery
- **Emergency** - Not an accident
- **Other** - If none of the above

Block 11 **Type of Service** - Enter the appropriate national code describing the type of service:

Block 11A **Procedure Code** - Enter the 5-digit CPT/HCPCS code, which was billed to Medicare. Each procedure must be billed on a separate line. Use the appropriate national procedure code modifier if

applicable.

Block 11B **Visits/Units/Studies** - Enter the units of service performed during the "Statement Covers Period" as billed to Medicare. (Block 13)

Block 12 **Date of Admission** –Enter the date of admission (if applicable).

Block 13 **Statement Covers Period** - Using six-digit dates, enter the beginning and ending dates of this service (from) and the last date of this service (thru), e.g., 03-01-03 to 03-31-03.

Block 14 **Charges to Medicare** - Enter the total charges submitted to Medicare.

Block 15 **Allowed by Medicare** - Enter the amount of the charges allowed by Medicare.

Block 16 **Paid by Medicare** - Enter the amount paid by Medicare (taken from the EOMB).

Block 17 **Deductible** - Enter the amount of the deductible (taken from the Medicare EOMB).

Block 18 **Coinsurance** - Enter the amount of the coinsurance (taken from the Medicare EOMB).

Block 19 **Paid by Carrier Other Than Medicare** - Enter the payment received from the primary carrier (other than Medicare). If Code 3 is marked in Block 7, enter an amount in this block. (Do not include Medicare payments).

Block 20 **Patient Pay Amount, LTC Only** - Leave blank.

Signature Signature of the provider or the agent and the date signed are required.

Mechanics and Disposition The information may be typed or legibly handwritten. Mail the completed claims to:

Department of Medical Assistance Services
Title XVIII
P. O. Box 27441
Richmond, Virginia 23261-7441

Retain a copy for the office files.

INVOICE PROCESSING

The Medicaid invoice processing system utilizes a sophisticated electronic system to process Medicaid claims. Once a claim has been received, imaged, assigned a cross-reference number, and entered into the system, it is placed in one of the following categories:

- Remittance Voucher
    - **Approved** - Payment is approved or placed in a pended status for manual adjudication (the provider must not resubmit).
    - **Denied** - Payment cannot be approved because of the reason stated on the remittance voucher.
- No Response - If one of the above responses has not been received within 30 days, the provider should assume non-delivery and rebill using a new invoice form. **The provider's failure to follow up on these situations does not warrant individual or additional consideration for late billing.**

EXHIBITS

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ 3. ____

2. ____ 4. ____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE***

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500,
APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

TITLE XVIII (MEDICARE) DEDUCTIBLE AND COINSURANCE INVOICE

VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

01 Provider's Medicaid ID Number	02 Last Name	03 First Name
04 Recipient ID Number	05 Patient's Account Number	06 Recipient's HIB Number (Medicare)

1

07 Primary Carrier Information Other Than Medicare ☐ 2 No Other Coverage ☐ 3 Billed and Paid ☐ 5 Billed No Coverage	08 Type Of Coverage Medicare ☐ A ☐ B	09 Diagnosis	10 Place of Treatment	11 Accident / Emer Ind ☐ ACC ☐ Emer ☐ Other	12 Type of Service	13 Procedure Code	14 Visits/Units, Studies

15 Date of Admission MM DD YY	16 Statement Covers Period From MM DD YY	Thru MM DD YY	17 Charges to Medicare	18 Allowed By Medicare	19 Paid By Medicare

20 Deductible	21 Co-Insurance	22 Paid By Carrier Other Than Medicare	23 Pat Pay Amt. LTC Only

2

07 Primary Carrier Information Other Than Medicare ☐ 2 No Other Coverage ☐ 3 Billed and Paid ☐ 5 Billed No Coverage	08 Type Of Coverage Medicare ☐ A ☐ B	09 Diagnosis	10 Place of Treatment	11 Accident / Emer Ind ☐ ACC ☐ Emer ☐ Other	12 Type of Service	13 Procedure Code	14 Visits/Units, Studies

15 Date of Admission MM DD YY	16 Statement Covers Period From MM DD YY	Thru MM DD YY	17 Charges to Medicare	18 Allowed By Medicare	19 Paid By Medicare

20 Deductible	21 Co-Insurance	22 Paid By Carrier Other Than Medicare	23 Pat Pay Amt. LTC Only

3

07 Primary Carrier Information Other Than Medicare ☐ 2 No Other Coverage ☐ 3 Billed and Paid ☐ 5 Billed No Coverage	08 Type Of Coverage Medicare ☐ A ☐ B	09 Diagnosis	10 Place of Treatment	11 Accident / Emer Ind ☐ ACC ☐ Emer ☐ Other	12 Type of Service	13 Procedure Code	14 Visits/Units, Studies

15 Date of Admission MM DD YY	16 Statement Covers Period From MM DD YY	Thru MM DD YY	17 Charges to Medicare	18 Allowed By Medicare	19 Paid By Medicare

20 Deductible	21 Co-Insurance	22 Paid By Carrier Other Than Medicare	23 Pat Pay Amt. LTC Only

4

07 Primary Carrier Information Other Than Medicare ☐ 2 No Other Coverage ☐ 3 Billed and Paid ☐ 5 Billed No Coverage	08 Type Of Coverage Medicare ☐ A ☐ B	09 Diagnosis	10 Place of Treatment	11 Accident / Emer Ind ☐ ACC ☐ Emer ☐ Other	12 Type of Service	13 Procedure Code	14 Visits/Units, Studies

15 Date of Admission MM DD YY	16 Statement Covers Period From MM DD YY	Thru MM DD YY	17 Charges to Medicare	18 Allowed By Medicare	19 Paid By Medicare

20 Deductible	21 Co-Insurance	22 Paid By Carrier Other Than Medicare	23 Pat Pay Amt. LTC Only

24 Remarks

THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.

SIGNATURE DATE

DMAS - 30 R 6/03

Instructions for the Completion of the Department of Medical Assistance Services (Title XVIII) Medicare Deductible and Coinsurance Invoice FOR PART B ONLY, DMAS-30 – R 6/03

Purpose: **To provide a method of billing Virginia Medicaid for Medicare deductible and coinsurance**.

NOTE: This form can be used for four different procedures **per** Medicaid recipient. A different form must be used for **each** Medicaid enrollee.

Block 01 **Provider's Medicaid ID Number** – Enter the Medicaid provider identification number assigned by Virginia Medicaid.

Block 02 **Recipient's Last Name** – Enter the last name of the patient as it appears from the enrollee's eligibility verification.

Block 03 **Recipient's First Name** – Enter the first name of the patient as it appears from the enrollee's eligibility verification.

Block 04 **Recipient ID Number** – Enter the 12-digit number taken from the enrollee's eligibility card.

Block 05 **Patient's Account Number** – Enter the financial account number assigned by the provider. This number will appear on the Remittance Voucher after the claim is processed.

Block 06 **Recipient's HIB Number (Medicare)** – Enter the enrollee's Medicare number.

Block 07 **Primary Carrier Information (Other Than Medicare)** – Check the appropriate block. (Medicare is not the primary carrier in this situation).

- **Code 2 – No Other Coverage** – If there is not other insurance information identified by the patient or no other insurance provided when the Medicaid eligibility is confirmed, check this block.
- **Code 3 – Billed and Paid** – When an enrollee has other coverage that makes a payment which may only satisfy in part the Medicare deductible and coinsurance, check this block and enter the payment in Block 22. If the primary carrier pays as much as the combined totals of the deductible and coinsurance, do not bill Medicaid.
- **Code 5 – Billed and No Coverage** – If the enrollee has other sources for the payment of Medicare deductible and coinsurance which were billed and the service was not covered or the benefits had been exhausted, check this block. Explain in the "Remarks" section.

Block 08 **Type of Coverage (Medicare)** – Mark type of coverage B only.

Block 09 **Diagnosis** – Enter the principal ICD-9-CM diagnosis code, omitting the decimal. Only one diagnosis code can be entered and processed.

Block 10 **Place of Treatment** – Enter the appropriate national place of service code.

Block 11 **Accident/Emergency Indicator** – Check the appropriate box, which indicates the reason the treatment, was rendered:

- **ACC** – Accident, Possible third-party recovery
- **Emer** – Emergency, Not an accident
- **Other** – If none of the above

Block 12 **Type of Service** – Enter the appropriate national code describing the type of service.

Block 13 **Procedure Code** – Enter the 5-digit CPT/HCPCS code that was billed to Medicare. Each procedure must be billed on a separate line. If there was no procedure code billed to Medicare, leave this block blank. Use the appropriate national procedure code modifier if applicable.

Block 14 **Visits/Units/Studies** – Enter the units of service performed during the "Statement Covers Period" (block 16) as billed to Medicare.

Block 15 **Date of Admission** – Enter the date of admission (if applicable).

Block 16 **Statement Covers Period** – Using six-digit dates, enter the beginning and ending dates of this service (from) and the last date of this service (thru) (e.g., 03-01-03 to 03-31-03).

Block 17 **Charges to Medicare** – Enter the total charges submitted to Medicare.

Block 18 **Allowed by Medicare** – Enter the amount of the charges allowed by Medicare.

Block 19 **Paid by Medicare** – Enter the amount paid by Medicare (taken from the Medicare EOMB).

Block 20 **Deductible** – Enter the amount of the deductible (taken from the Medicare EOMB).

Block 21 **Co-insurance** – Enter the amount of the co-insurance (taken from the Medicare EOMB).

Block 22 **Paid by Carrier Other Than Medicare** – Enter the payment received from the primary carrier (other than Medicare). If the Code 3 is marked in Block 7, enter an amount in this block. (Do not include Medicare payments).

Block 23 **Patient Pay Amount, LTC Only** – Enter the patient pay amount, if applicable.

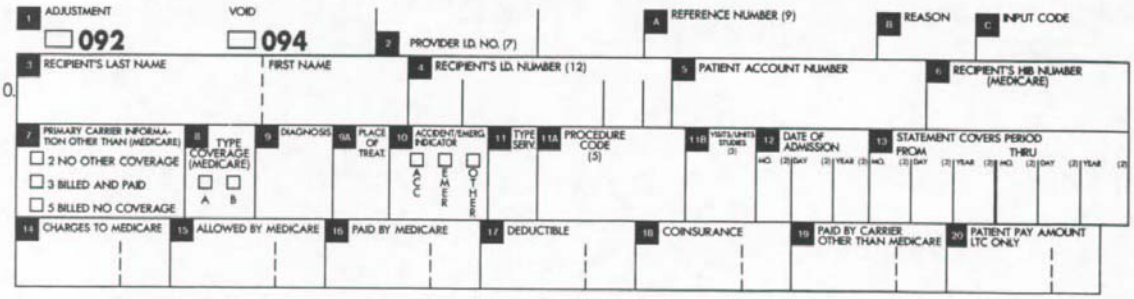
Block 24 **Remarks** – If an explanation regarding this claim is necessary, the "Remarks" section may be used. Submit only original claim forms and attach a copy of the EOMB to the claim.

Signature Note the certification statement on the claim form, then sign and date the claim form.

TITLE XVIII (MEDICARE) DEDUCTIBLE AND COINSURANCE INVOICE

VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES



0.

_____ DATE OF REMITTANCE VOUCHER CLAIM WAS APPROVED

THIS FORM IS FOR CHANGING OR VOIDING A PAID ITEM. THE CORRECT REFERENCE NUMBER OF THE PAID CLAIM AS SHOWN ON THE REMITTANCE VOUCHER IS ALWAYS REQUIRED.

REMARKS:

THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.

SIGNATURE DATE

ORIGINAL COPY

DMAS 31 R 6/96

Instructions for the Completion of the Department of Medical Assistance Services (Title XVIII) Medicare Deductible and Coinsurance Adjustment Invoice FOR PART B ONLY, DMAS-31 (Revised 6/96)

Adjustment Coinsurance Invoice, DMAS-31 (Revised 6/96)

The adjustment invoice is used to change information on a **paid** claim. This form cannot be used for the follow-up of denied or pended claims.

Void Coinsurance Invoice, DMAS-31 (Revised 6/96)

The void invoice is used to void the original payment. The information on the invoice must be identical to the original invoice.

Purpose	To provide a means of making corrections or changes to claims that have been approved for payment. This form cannot be used for the follow-up of denied, or pended claims. (See the "Exhibits" section at the end of this chapter for a sample of this form).
Explanation	To void the original payment, the information on the adjustment invoice must be identical to the original invoice. To correct the original payment, the adjustment invoice must appear exactly as the original should have.
Block 1	**Adjustment/Void** - Check the appropriate block.
Block 2	**Provider Identification Number** – Enter the Virginia Medicaid provider identification number assigned by Virginia Medicaid.
Block 2A	**Reference Number** - Enter the reference number/ICN taken from the Remittance Voucher for the line of payment needing an adjustment. The adjustment cannot be made without this number since it identifies the original invoice.
Block 2B	**Reason** - Leave blank.
Block 2C	**Input Code** - Leave blank.
Block 3	**Clients' Name** - Enter the last name and the first name of the patient as they appear on the enrollee's eligibility card.
Block 4	**Client's Identification Number** - Enter the 12-digit number taken from the enrollee's eligibility card.
Block 5	**Patient Account Number** – Enter the financial account number assigned by the provider. This number will appear on the Remittance voucher after the claim is processed.
Block 6	**Client HIB Number** (Medicare) - Enter the enrollee's Medicare number.
Block 7	**Primary Carrier Information (Other Than Medicare)** - Check the appropriate block. (Medicare is not the primary carrier in this situation).

- **Code 2 - No Other Coverage** –If there is no other insurance information identified by the patient or no other insurance provided when the Medicaid eligibility is confirmed, check this block.

- **Code 3 - Billed and Paid** - When an enrollee has other coverage that makes payment which may only satisfy in part the Medicare deductible and coinsurance, check Block 3 and enter the payment received in Block 19. If the primary carrier pays as much as the combined totals of the deductible and coinsurance, do not bill Medicaid.

- **Code 5 - Billed and No Coverage** - If the enrollee has other sources for the payment of Medicare deductible and coinsurance which were billed and the service was not covered or the benefits had been exhausted, check this block. Explain in the "Remarks" section.

Block 8 **Type Coverage (Medicare)** - Mark type of coverage "B".

Block 9 **Diagnosis** - Enter the primary ICD-9-CM diagnosis code, omitting the decimal. Only one code can be processed.

Block 9A **Place of Treatment** - Enter the appropriate national place of service code:

Block 10 **Accident Indicator** - Check the appropriate box which indicates the reason the treatment was rendered:

- **Accident** - Possible third-party recovery
- **Emergency** - Not an accident
- **Other** - If none of the above

Block 11 **Type of Service** - Enter the appropriate national code describing the type of service:

Block 11A **Procedure Code** - Enter the 5-digit CPT/HCPCS code, which was billed to Medicare. Each procedure must be billed on a separate line. If there is no procedure code billed to Medicare, leave this blank. Use the appropriate national procedure code modifier if applicable.

Block 11B **Visits/Units/Studies** - Enter the units of service performed during the "Statement Covers Period" as billed to Medicare. (Block 13)

Block 12 **Date of Admission** –Enter the date of admission (if applicable).

Block 13 **Statement Covers Period** - Using six-digit dates, enter the beginning and ending dates of this service (from) and the last date of this service (thru), e.g., 03-01-03 to 03-31-03.

Block 14 **Charges to Medicare** - Enter the total charges submitted to Medicare.

Block 15 **Allowed by Medicare** - Enter the amount of the charges allowed by Medicare.

Block 16 **Paid by Medicare** - Enter the amount paid by Medicare (taken from the EOMB).

Block 17 **Deductible** - Enter the amount of the deductible (taken from the Medicare EOMB).

Block 18	**Coinsurance** - Enter the amount of the coinsurance (taken from the Medicare EOMB).
Block 19	**Paid by Carrier Other Than Medicare** - Enter the payment received from the primary carrier (other than Medicare). If Code 3 is marked in Block 7, enter an amount in this block. (Do not include Medicare payments).
Block 20	**Patient Pay Amount, LTC Only** - Leave blank.
Signature	Signature of the provider or the agent and the date signed are required.

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

CLAIM ATTACHMENT FORM

Attachment Control Number (ACN) :

Patient Account Number (20 positions limit)*	**MM**	**DD**	**CCYY**	**Sequence Number (5 digits)**
		Date of Service		

*Patient Account Number should consist of numbers and letters only. NO spaces, dashes, slashes or special characters.

Provider Number:	**Provider Name:**

Enrollee Identification Number:

Enrollee Last Name:	**First Name:**	**MI:**

☐ **Paper Attached** ☐ **Photo(s) Attached** ☐ **X-Ray(s) Attached**

☐ **Other (specify)** _____

COMMENTS: _____

_____

_____

_____

_____

_____

THIS IS TO CERTIFY THAT THE FOREGOING AND ATTACHED INFORMATION IS TRUE, ACCURATE AND COMPLETE. ANY FALSE CLAIMS, STATEMENTS, DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS

Authorized Signature _____ **Date Signed** _____

Mailing addresses are available in the Provider manuals or check DMAS website at www.dmas.state.va.us . Attachments are sent to the same mailing address used for claim submission. Use appropriate PO Box number.

DMAS - 3 R 6/03

INSTRUCTIONS FOR THE COMPLETION OF THE DMAS-3 FORM. THE DMAS-3 FORM IS TO BE USED BY EDI BILLERS ONLY TO SUBMIT A NON-ELECTRONIC ATTACHMENT TO AN ELECTRONIC CLAIM.

Attachment Control Number (ACN) should be indicated on the electronic claim submitted. The ACN is the combined fields 1, 2 and 3 below. (i.e. Patient Account number is 123456789. Date of service is 07/01/2003. Sequence number is 12345. The ACN entered on the claim should be 123456789070120031 2345.)
IMPORTANT: THE ACN ON THE DMAS-3 FORM MUST MATCH THE ACN ON THE CLAIM OR THE ATTACHMENT WILL NOT MATCH THE CLAIM SUBMITTED. IF NO MATCH IS FOUND, CLAIM MAY BE DENIED. ATTACHMENTS MUST BE SUBMITTED AND ENTERED INTO THE SYSTEM WITHIN 21 DAYS OR THE CLAIM MAY RESULT IN A DENIAL.

1. **Patient Account Number** – Enter the patient account number up to 20 digits. Numbers and letters only should be entered in this field. **Do not** enter spaces, dashes or slashes or any special characters.

2. **Date of Service** – Enter the from date of service the attachment applies to.

3. **Sequence Number** –Enter the provider generated sequence number up to 5 digits only.

4. **Provider Number** – Enter the Medicaid Provider number.

5. **Provider Name** – Enter the name of the Provider.

6. **Enrollee Identification Number** – Enter the Medicaid ID number of the Enrollee.

7. **Enrollee Last Name** - Enter the last name of the Enrollee.

8. **First** – Enter the first name of the Enrollee.

9. **MI** – Enter the middle initial of the Enrollee.

10. **Type of Attachment** – Check the type of attachment or specify.

11. **Comment** – Enter comments if necessary.

12. **Authorized Signature** – Signature of the Provider or authorized Agent.

13. **Date Signed** – Enter the date the form was signed.

Attachments are sent to the same mailing address used for claim submission. Use appropriate PO Box number. Mailing addresses are available in the Provider manuals or check the DMAS website at www.dmas.state.va.us.